Division of
Emergency Management

Palm Beach County Special Needs Registration

APPLICATION DATE:_____

BASIC INFORMATION

LAST:_____FIRST:_____ HOME PHONE:_____

ADDRESS:_____APT/LOT #:_____

CITY:_____ZIP:_____ CELL PHONE: _____

E-MAIL:_____

MAILING ADDRESS: □ SAME AS ABOVE _____

CITY:_____ZIP:_____ Do you live above the ground level? □ YES or □ NO

DATE OF BIRTH:____/____/____ HEIGHT_____WEIGHT_____ GENDER: □ MALE or □ FEMALE

DWELLING TYPE: □ SINGLE FAMILY □ MOBILE HOME □ APT/CONDO □ OTHER

DEVELOPMENT NAME:_____GATE CODE:_____LANGUAGE SPOKEN_____

EMERGENCY CONTACTS & CAREGIVER INFORMATION

CAREGIVER—Do you have a caregiver that will accompany you to the shelter? □ YES or □ NO

NAME:_____ RELATIONSHIP:_____PHONE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

Does your caregiver have special needs? □ YES or □ NO If yes, explain:_____

_____

EMERGENCY CONTACTS

(LOCAL) NAME:_____ RELATIONSHIP:_____PHONE:_____

(NON-LOCAL) NAME:_____RELATIONSHIP:_____PHONE:_____

MEDICAL SUPPORT INFORMATION

PRIMARY DOCTOR:_____PHONE:_____

HOME HEALTH AGENCY:_____PHONE:_____

HOME MEDICAL EQUIPMENT PROVIDER:_____PHONE:_____

DIALYSIS CENTER:_____PHONE:_____

OXYGEN SUPPLIER:_____PHONE:_____

ASSISTANCE REQUIRED

1. **Do you need transportation to a special needs shelter?** □ YES or □ NO (own car)
   If "yes", check one: □ Palm Tran Connection Bus □ Ambulance (stretcher type transport)
2. **Assistance with Daily Living: (check all that apply)**
   □ Toileting □ Taking Medications □ Feeding/Eating □ Walking more than 50 ft. □ Getting out of bed □ Dressing
3. **Can you sleep on a cot?** □ YES or □ NO (beds & hospital beds are not provided)

SPECIAL NEEDS (check all that apply)

Electric Dependent

☐ Bi-Pap ☐ C-Pap
☐ Cardiac Monitor ☐ Feeding Pump
☐ Nebulizer ☐ Suction Pump
☐ Oxygen Concentrator

☐ Oxygen: ____of hours daily at ____liters per minute

☐ Dialysis: (#)_____days per week

☐ Ventilator: **Arrangements must be made with a physician for patient to stay at a hospital. The Special Needs Shelter is not equipped to handle ventilator patients.**

Mobility Assessment

☐ I can walk ☐ Wheelchair/scooter
☐ Walker ☐ Cane
☐ Deaf ☐ Hearing Impaired
☐ Blind ☐ Partially Blind
☐ Lift used to get out of bed
☐ Bedridden

Cognitive Assessment

☐ Mental health problem
☐ Psychiatric or personality disorder
☐ Alzheimer ☐ Dementia
☐ Autism ☐ Conduct disorder
☐ Anxiety ☐ Depression
☐ Obsessive Compulsive

Specialized Equipment

☐ Feeding Tube ☐ IV Equipment
☐ Service Animal
☐ Other_____

Special Care/Considerations

☐ Ostomy ☐ Catheter
☐ Morbid obesity
☐ Open wounds/Decubitus
☐ Incontinence
☐ Wear Adult Diapers

☐ **I need a nurse or caregiver to administer medications.**

DIAGNOSIS & MEDICATIONS (list medication name and dose)

List your medical problems:_____

_____

_____

_____

Allergies: ☐ YES or ☐ NO If yes, list:_____

Medications (attach additional pages if needed):

Prescription Name	Dose	How often	Prescription Name	Dose	How often

Form Completed By:_____Relationship:_____Phone:_____

By submitting this form, I give my authorization for the Palm Beach County Special Needs program to release this information to other emergency response personnel, human service agencies, officials or those they deem necessary to facilitate the evaluation of this application and required activities to ensure assistance for me. Records relating to registration of disabled citizens are exempt as listed in the provisions of F.S. 119.07 (1), Public Records Law. The information contained herein will be kept confidential. I also understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care, I understand that I must make these arrangements myself.

_____ _____

Signature of Patient / Guardian Date

Return form to: Palm Beach County Division of Emergency Management; 20 South Military Trial West Palm Beach, FL 33415 OR Fax 561-712-6464. For more information, call 561-712-6400.